ON VESICO-URETHRO-VAGINAL FISTULA.

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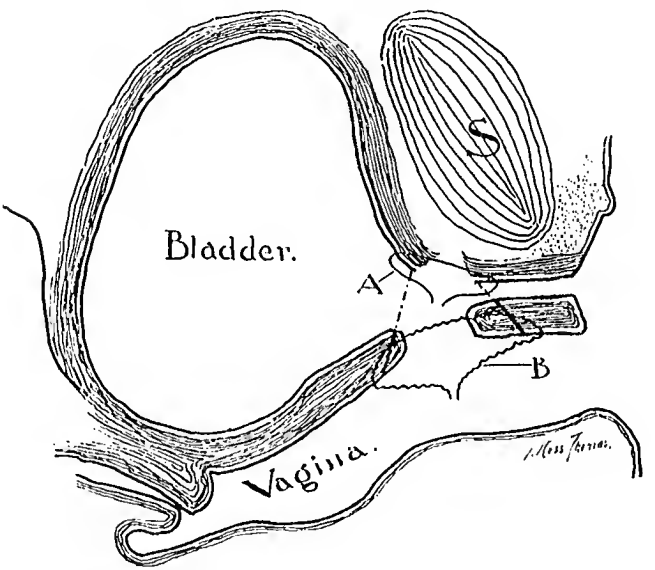
CASES of vesico-vaginal fistulæ, in these days of improved obstetrical procedures, are comparatively rare, but still occur with sufficient frequency to make their successful treatment a matter of interest to surgeons. Since Marion Sims's brilliant work, the cure of this affection has not attracted very much attention, both on account of the modern use of forceps in obstetrics dispensing with prolonged labors, and because the technique he originated left little to be desired in the ordinary type of cases. However, in spite of these facts, one occasionally sees, even in our large cities, women who have undergone numerous operations and are still uncured. It is probably the rule that all vesico-vaginal fistulæ, except the smallest and simplest ones, require a series of operations before the case is complete.

The case, whose report follows, presented a very unusual lesion,—vesico-urethro-vaginal fistula. The operation done is, so far as I can learn, original.

CASE.—Mrs. F. C., Mexican, primipara, aged twenty-two, had had good health previously. She was confined January, 1899, and was attended by an ignorant midwife, who permitted the labor to continue about forty-eight hours before the child was born. A few days after confinement the urine passed from the vagina, and in a short while all of it came in this way. Such had been her condition for several weeks, when Dr. J. A. Samaniego was called to see the case. Dr. Samaniego had Dr. F. W. Gallagher in consultation, and these two gentlemen kindly referred the case to me for operation. On examination, the urethra and bladder were found completely disconnected, the urethra being a functionless tube. The opening into the bladder was about a half-inch in diameter, the distance between the lower part of this opening and the lower part of the urethra one

and a half inches, and between the upper part of the vesical opening and the upper part of the urethra a half-inch. In other words, there had sloughed out a triangular mass of tissue, including part of the neck of the bladder and the whole thickness of the urethra, with its base towards the vagina and apex, behind the symphysis pubis. Cystocele was present.

Operation performed April 25, 1899, under chloroform anæsthesia. Patient was placed in the Sims's position. I had at first expected to dissect the bladder from the uterus and possibly from the



vagina, but an ample cystocele permitted approximation of the parts without too much tension. I first denuded the tissues around the opening in the bladder down to the vesical mucous membrane; then, so as to make the diameter of the opening in the urethra equal to that in the bladder, and at the same time to get rid of some irregular scar tissue, the urethra was cut obliquely (as shown in the figure). Two silk sutures were inserted, going through the mucous membrane and muscular coat of the bladder and the upper part of the urethra (*A* in the cut). These approximated the upper part of

the vesical opening and the corresponding portion of the urethra. Then four sutures of fine silkworm gut coapted the lower portion of the vesical and urethral openings (*B*). These did not penetrate the mucous membrane. On account of the existing cystocele the bladder could be readily pulled forward. A catheter was then inserted through the urethra and another through a small incision made in the base of the bladder. This provided for ample drainage. The catheter in the base of the bladder accidentally came out four days after operation, and was not reinserted. The one in the urethra was removed a week later. The silkworm-gut sutures were removed twelve days after operation. The silk sutures were, of course, left. The incision in the base of the bladder closed after the catheter came out and was not reopened. The middle portion of the sutured wound healed nicely, but two fistulæ remained, one at each end of the wound. On May 19, 1899, a second operation was performed, and an attempt made to close them, with only a partially successful result. Both fistulæ were diminished in size by this operation, but neither was closed. An operation under cocaine anæsthesia, two weeks later, obliterated the smaller fistula. Patient left the hospital on June 9, 1899, still leaking some. The smallness of the vagina, the presence of some remaining cystocele, the location of the lesion just behind the pubic symphysis, and the adjacent scar tissue made this last fistula exceedingly difficult to operate upon. The chances of success were also decreased by the impossibility of keeping the patient quiet and the disregard of my directions by both her and her husband. She was operated on five times at my office under cocaine anæsthesia before I succeeded in completely closing this fistula, which I did, however, at the last operation, on October 3, 1899.

The bladder is now performing its function properly, and the fistulous openings are firmly closed. A portion of the sphincter vesicæ was destroyed by the trauma from prolonged labor, but enough muscle fibres remained to perform the work of the sphincter in a fairly satisfactory manner.